ADDRESSOGRAPH

DISTRIBUTION: **WHITE** - DHSS; **CANARY** - SUBMITTER

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
NEWBORN HEARING SCREENING RESULTS REPORT EOAA EMPLOYER

1. TYPE OF SCREENING (Check only one) ☐ INITIAL ☐ RESCREEN

2. RACE CODE (Check all that apply)
☐ W - WHITE ☐ N - AM INDIAN/ALASKAN
☐ B - BLACK ☐ P - PACIFIC ISLANDER
☐ A - ASIAN ☐ O - OTHER _____

3. SEX ☐ M - MALE ☐ F - FEMALE

4. BIRTHWEIGHT GRAMS OR LBS OZ

5. GESTATION AGE (WEEKS) ☐☐

6. BIRTH ORDER OF MULTIPLE BIRTHS (ENTER A - F, S = SINGLE)

7. REFUSED

8. BABY'S NAME (LAST, FIRST)

9. HEARING SCREENING RESULTS

RIGHT EAR		LEFT EAR	
☐ 1 - ABR	☐ P - PASS	☐ 1 - ABR	☐ P - PASS
☐ 2 - OAE	☐ R - REFER	☐ 2 - OAE	☐ R - REFER
☐ 3 - MISSED	DATE SCREENED _____	☐ 3 - MISSED	DATE SCREENED _____
☐ 4 - OTHER _____		☐ 4 - OTHER _____	

10. DATE OF BIRTH TIME :

11. BIRTHING FACILITY NAME

12. BABY'S MEDICAL RECORD NUMBER

13. MOTHER'S MEDICAL RECORD NUMBER

14. MOTHER'S NAME (LAST, FIRST)

15. ALTERED HEALTH STATUS (Check all that apply)
☐ 1 - PREMATURE ☐ 4 - TRANSFUSD WITH RED BLOOD CELLS,
☐ 2 - SICK DATE AND TIME: _____
☐ 3 - ANOMALIES ☐ 5 - DECEASED

16. MOTHER'S STREET ADDRESS/P.O. BOX

17. MOTHER'S PHONE NUMBER

18. CITY

19. STATE

20. ZIP CODE

21. MOTHER'S COUNTY OF RESIDENCE

22. MOTHER'S S.S. NO.

23. MOTHER'S MEDICAID NO.

24. BABY'S PRIMARY CARE PHYSICIAN (LAST, FIRST) OR CLINIC

COMPLETE SUBMITTER NAME, ADDRESS, TELEPHONE & FAX NUMBER OR AFFIX SUBMITTER LABEL

FOR HEARING SCREENING ONLY

MO 580-1919 (1-04) BGDP-3

INSTRUCTIONS - NEWBORN HEARING SCREENING REPORTING FORM

GENERAL

Use this form to report identifying information and initial hearing screening or rescreening results on newborns only.

Submit white copy to the Missouri Department of Health and Senior Services - Metabolic Lab, PO Box 570, Jefferson City, MO 65102-0570. All hearing screening reports must be reported **no more than seven (7) days following the completion of the initial hearing screening or any rescreening. Complete the lower right hand box with submitter information, or if available, affix submitter label.**

SPECIFIC INSTRUCTIONS

ITEM

1. **TYPE OF SCREENING** Check the type of screening. **Initial** hearing screenings are those hearing screenings performed during the birth admission, **prior to hospital discharge.** A **rescreen** is any hearing screening performed on an outpatient basis. Exceptions include an initial hearing screening "missed" or not performed during the birth admission due to equipment problems, environment disturbances, or early discharge.
2. **RACE CODE** Check all that apply.
3. **SEX** Check applicable sex.
4. **BIRTH WEIGHT** Enter baby's weight at birth, preferably in grams.
5. **GESTATION AGE** Enter gestation age at birth in weeks.
6. **BIRTH ORDER OF MULTIPLE BIRTHS** Enter "S" for single birth, and "A-F" to designate birth order.
7. **REFUSED Write "yes" in the box if parent(s) or guardian(s) refuse the screening.** Leave box blank if the hearing screening was performed.

ITEM (con't):

8. **BABY'S NAME** Enter baby's complete name, if known.
9. **HEARING SCREENING INFORMATION** Check the method used to perform the most recent hearing screening for the right ear and the left ear. Check pass or refer for each ear and record the date of the most recent screening for each ear before discharge. Check missed if you are unable to perform the hearing screening before the baby is discharged.
10. **BABY'S DATE AND TIME OF BIRTH** Enter baby's date of birth as MM/DD/YY, and time of birth in military time (i.e. 1:00 p.m is 13:00 hrs.)
11. **BIRTHING FACILITY NAME** Enter the name of facility where baby was born.
12. **BABY'S MEDICAL RECORD NUMBER** Enter medical record number, if available.
13. **MOTHER'S MEDICAL RECORD NUMBER** Enter number.
14. **MOTHER'S NAME** Enter mother's first and last name.
15. **ALTERED HEALTH STATUS** Check all that apply.
16. **MOTHER'S STREET ADDRESS** Enter mother's street address
17. **MOTHER'S PHONE NUMBER** Enter current area code and phone number.
18. - 21. **MOTHER'S CITY, STATE, ZIP CODE, AND COUNTY OF RESIDENCE** Enter all available information.
22. **MOTHER'S S.S. NUMBER** Enter mother's social security number.
23. **MOTHER'S MEDICAID NUMBER** Enter if applicable
24. **BABY'S PRIMARY CARE PHYSICIAN OR CLINIC** Enter the name of the primary care physician or clinic that will undertake the pediatric care of the baby **following discharge.**

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